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ABSTRACT

The document contains policies and guidelines for the Child Center of Our Lady of Grace, a facility offering psychiatric evaluation and treatment for children (ages 4 to 17) in the St. Louis (Missouri and Illinois) region. After a brief statement of program rationale and an introduction to the program, services and policies are described. Individual sections focus on the following program components: evaluation; children's day treatment; children's residential treatment; adolescent day treatment; outpatient treatment services; psychotherapy; and planning, budgeting, finance, and fees. A flow chart of the intake and evaluation process is provided. Briefly discussed for the children's day treatment program are the following therapies: educational, activity, art, expressive, music, and recreational. A section on operation of the center includes policies on program schedules, transportation, parental authorization, restrictions and limitations on children's behavior, students and volunteers, meetings, gifts and donations, research, employees, and the physical plant. (DB)

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CHILD CENTER OF OUR LADY OF GRACE

STATEMENT OF POLICIES AND GUIDELINES

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RATIONALE

The general scarcity of psychotherapists for children and the highly expensive nature of individual psychotherapy has made it imperative to use new techniques and methods in facing the wide varieties of emotional and behavioral disturbance in children. Some of these techniques, particularly the multidisciplinary team treatment approaches, have proven to be superior in therapeutic results.

Here at the CHILD CENTER OF OUR LADY OF GRACE we cannot fit our children patients into a neat clinical package, since within any of the classification categories a great variety of behaviors, etiologies, potentials and prognoses are observable. We deal with children who suffer from problems of hyperactivity and impulse control; children who are depressed, lethargic, dependent, withdrawn or immature; children who are regressed and infantile, precocious or overly-independent; children who suffer from various degrees of handicaps or deficits in learning (academic and social skills); and children who are suffering from brain damage, brain dysfunction and/or serious emotional disorders such as schizophrenia. The age span of boys and girls treated in our facility ranges between 3 and 19.

Unfortunately, classifying these children in clinical categories doesn't solve any problem for us, since in each diagnostic category we are dealing with hundreds of potentially different facets and modes of behavior. In a modern and progressive child psychiatric center, such as the CHILD CENTER, the need for a different type of classification, with multi-faceted orientations, becomes clearer everyday.

A great number of children who are referred to us are suffering from speech, language and communication problems which, added to the rest of their emotional and behavioral disturbances, call for a team of specialists from many backgrounds and disciplines (i.e., expressive therapy, special education, psychology, psychiatry, social work, art, recreation, occupational, and residential therapy) to coordinate efforts in dealing with the child.

Every child is in need of an individual prescription to provide for his behavioral, psychological, educational, and family needs. It is necessary to appraise his special skills, strengths, deficits, developmental lags, disabilities, limitations and family dynamics. It is necessary to evaluate his sensory perception, neuro-motor development, spatial relationships, body image, discrimination, attention and focusing; his ability to use symbols, to communicate, to understand and develop concepts; conflicts related to his early childhood; his existential anxieties, behavioral difficulties, impulse control and general level of ego development. We are aware that the psychological and psychoeducational assessment never ends and can never be complete. It is a process in constant evolution. Every new discovery about the child creates and poses new questions which bring the validity of our original formulations and hypotheses into more focus.

Among staff members in the CHILD CENTER the role of the "educational therapist" is one of utmost significance. He observes and deals with the child consistently and continuously, day after day, for long hours in the classroom, the therapeutic intervention room and in the multitude of everyday living conditions. This role is, however, heavily influenced by that of the rest of the

staff, who are also dealing with the child's inner conflicts, ego functions, growth and treatment and systematically with his family environment.

The idea that learning and behavior problems of emotionally disturbed children are all directly related to their childhood experiences and parental handling is a very naive thought, rejected by modern concepts of transactions and general systems. We perceive the child as an active organism, containing within himself numerous functional systems, interacting and interrelating to each other and to the environment. A child's emotional and/or behavioral problem can be studied and understood on many different levels. Chemical, cellular and organic characteristics, temperamental and constitutional factors, heredity, learning, interaction with the environment, intrapsychic and intrapersonal conflicts, interpersonal, familial, social and transactional influences are all important.

Many of the children treated at CHILD CENTER lack the essential organization to control their impulses and are in need of structure to receive such controls from outside. Many of them, on the other hand, do have the internal organization but, living for a number of years in circumstances of inconsistency, can't follow any routine or regulations. Some of our children have had traits which were not considered ideal or desirable in their family environment. In order to change these traits, they have been exposed to techniques of coercion, coaxing, manipulating, evaluation, masking, postponing, etc. They have then reacted to these situations by counter-coercion, rebellion, refusing, defying, provoking or unmasking.

There isn't any single generalization that we could use and apply to all behavioral, emotional and learning difficulties of our children. In a great number of them, we are dealing with basic "ego" weaknesses. They have deficiencies or lags in terms of impulse control, frustration tolerance, gratification delay, adaptation to environmental situations, attention, focusing, discrimination, perceptual intake and integration of associations, appraisals, imagination and thoughts. Still others show conflicts around the issues of autonomy and identity. Some children function as identified patients or as scapegoats in their families, diverting the family pathology to themselves. These elements reveal the fact that in dealing with child patients we need multi-disciplinary and well-coordinated programs.

Our first step in dealing with children referred to us, is recognizing and separating their conflicts from their problems. Being aware of the malignant, repetitious nature of conflicts and the need for various types of psychotherapy to deal with them, we like to identify and separate these conflicts from different problems which are not conflictual; hence, are easier to treat. Recognizing that children are dynamic and open beings, constantly under the impact of their family and peer group influence, that their relationships are not all transference relationships connected to past experiences, that they have emerging relationships and roles affected by now and here, the rationale of the CHILD CENTER'S program is to create a dynamic and flexible schedule. Such a program can evaluate, appraise, recognize and focus on treatment and handling of a variety of different emotional, behavioral and family problems, learning disabilities, etc., under the basic principle of anticipatory guidance. We understand that pathology is not "fixated" in a majority of our patients and they are open to change when exposed to a comprehensive plan of treatment.

We assume that until a child enters the Center, his impact on his peer group and staff, and the impact of the Center on him or his family cannot be predicted. When a child enters the program, he will establish two types of relationships, some new and independent, and some related to habits and behavior traits of the past. This is true for his family members as well.

The comprehensive program used at the CHILD CENTER focuses on rebuilding and developing ego functions, analysis, appraisal and understanding of various conflicts, family interactions and behavioral deviations. It tries to teach the children more appropriate object relationships and enhance their reality testing. We try to increase their tolerance for frustration, improve their learning and academic achievement, enhance their communication abilities, and create in them the feelings of empathy and love for others. For the families, we try to improve communication, empathy, task efficiency, clarity of boundaries and problem resolution.

The children's basic needs of being, belonging, learning, achieving and creating are constantly met by different staff members, side by side with the treatment which attacks their problems.

INTRODUCTION

The CHILD CENTER OF OUR LADY OF GRACE is a private, non-profit organization incorporated in the State of Missouri in 1948. It is governed by a 48 member Board of Directors who represent the community both as consumers and as professional providers. The Board meets monthly and has regular committees to set the policies of the CHILD CENTER, to oversee their implementation, and to be responsible for the CHILD CENTER'S budget.

The day-to-day management of the CHILD CENTER is the responsibility of two people, the Medical Director and the Administrative Director. The Medical Director is primarily responsible for treatment services provided by the agency. The Administrative Director is primarily responsible for financial management, personnel management and other operating details including integration of the CHILD CENTER'S service programs.

As a treatment and evaluation center for emotionally and behaviorally disordered children and youth, the CHILD CENTER has five basic services:

Comprehensive psychiatric evaluation
Day treatment for children
Residential treatment for children
Day treatment for adolescents
Outpatient therapy for children, adolescents and their families

These programs are designed to serve the needs of children of all races, creeds, and national origin, from ages four through seventeen. There are no geographic restrictions on the services offered by the CHILD CENTER. We primarily serve families living within St. Louis City, St. Louis County, St. Charles County and neighboring counties in the State of Illinois. The professional staff includes a child psychiatrist who is the Medical Director, clinical psychologists, psychiatric social workers, and educational, recreational, music, art, expressive and residential therapists.

A staff committee of department heads meets regularly to assist the Medical

Director and the Administrative Director in decision making for operating policies and procedures. Secondary to this, the department heads share information among otherwise busy supervisors. Each of the department heads has primary responsibility for effective management of his or her own department. Each meets weekly with the Administrative Director to discuss operating details and participates actively in development of treatment services to clients.

The CHILD CENTER is a private agency but is approved by the Missouri Department of Elementary and Secondary Education, the Illinois Office of Education, the Missouri and Illinois Departments of Mental Health, and is licensed by the Missouri Division of Family Services.

Statements made here are general guidelines on how we operate. While they delineate the basic attitudes and philosophy of service rendered by the staff, the agency recognizes the value of individual personal strengths as well as the presence of personal weaknesses. Consequently, in establishing meaningful relationships with clients, staff members are actively encouraged to be innovative and to be responsible for creative approaches to treatment.

Treatment of the individual child and his family is regularly reviewed by all the staff working with the individual child in case review meetings.

The individual needs of each child are primary in arriving at any decision in terms of treatment planning. Flexibility is the watchword.

DESCRIPTION OF SERVICES AND POLICIES

A. EVALUATION

Parents are required to initiate contacts with the CHILD CENTER and actively participate in the evaluation process. Referring agencies and other parties interested in the child in difficulty are asked to have the parents call us for a telephone interview. The CHILD CENTER'S intake social worker will then talk with the parents over the telephone and decide with them which of the CHILD CENTER'S programs, if any, seem to have potential for helping their child. If the children's residence or the children's or adolescents' day treatment program seems suitable, an interview at the CHILD CENTER is arranged with the intake worker for the entire family or household. This is done within 48 hours if possible. If residence or day treatment programs do not seem needed but outpatient treatment seems suitable, then the family is referred to the outpatient service which is involved in individual, family, parent and marital psychotherapy and educational therapy for children or adolescents. In this case the entire family or household group is seen by the clinical psychologist in charge of outpatient services within 2 days unless the family is unable to do so. If outpatient services are considered inappropriate then referral is made to other agencies or back to the intake social worker if residence or day treatment appears now to be needed. The intake social worker will, of course, also refer other agencies if none of our services appear to be helpful.

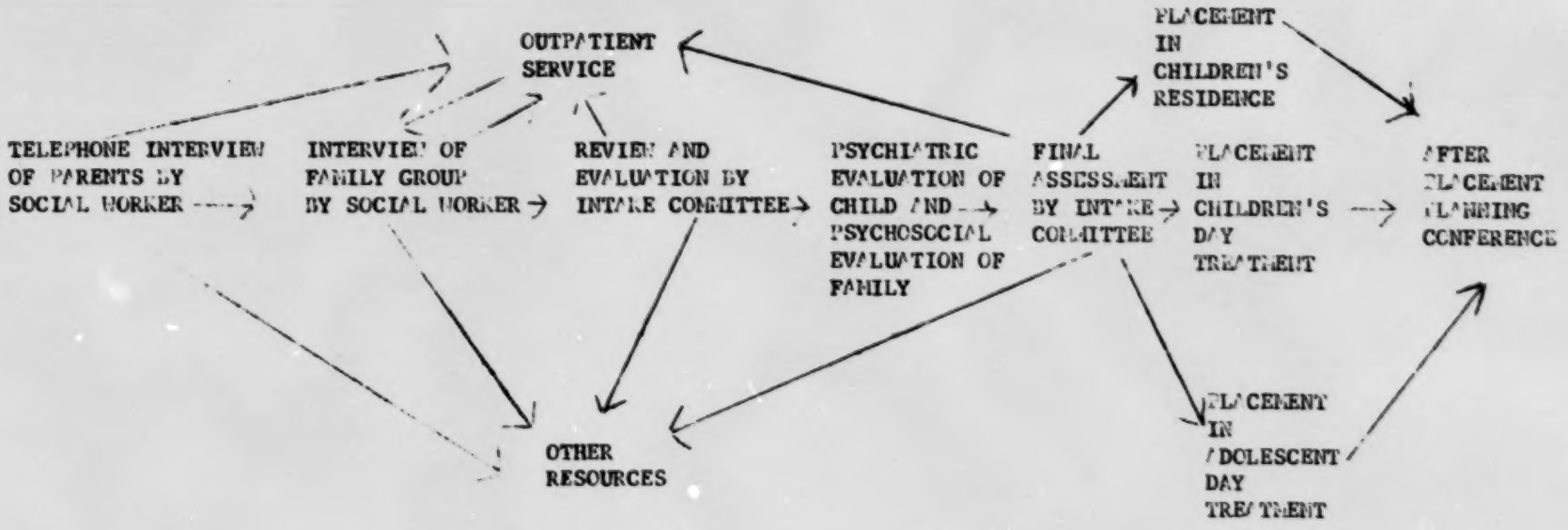
For families and children who appear to have potential for benefiting from our programs, information may be requested from schools and other agencies with whom the families and children have had previous contact concerning

their problems. For children and adolescents thought to be suitable for day treatment or residential treatment, information obtained in the initial family interview and outside sources is reviewed by an intake committee consisting of the CHILD CENTER'S Medical Director, Administrative Director, staff psychologist, chief social worker, directors of the children's and adolescent day treatment programs and the residential unit, and the intake social worker. If a child is still seen as suitable for a CHILD CENTER program, a complete evaluation is then done. This consists of a psychosocial interview with the family by a social worker and a psychiatric interview with the child or adolescent by the Medical Director. Psychological testing is done if more definitive psychological information is indicated and it hasn't been obtained from schools or other agencies. The Administrative Director also meets with the parents to discuss fees. When this phase of the evaluation has been completed, all information is again discussed by the intake committee which decides whether the child will enter residence or day treatment. (Children in the residence attend school with the children in the day treatment program). Otherwise, they refer to other programs or to our outpatient service.

Prior to admission, each child is involved in a "diagnostic classroom" session. Here the child's academic strengths and weaknesses are assessed and the child is enrolled in the classes with the most compatible peer groups and teachers. Final financial arrangements are then made with the Administrative Director. After the child or adolescent has been observed in his program for several weeks, a planning conference is held with all staff members involved. At this time, definite treatment goals and plans for implementing them are made.

Children with mental retardation, cerebral palsy, severe physical handicaps or emotional disorders requiring hospitalization are not admitted to CHILD CENTER programs.

INTAKE AND EVALUATION AT THE CHILD CENTER


OUTPATIENT SERVICE
PLACEMENT IN CHILDREN'S RESIDENCE
TELEPHONE INTERVIEW OF PARENTS BY SOCIAL WORKER
INTERVIEW OF FAMILY GROUP BY SOCIAL WORKER
REVIEW AND EVALUATION BY INTAKE COMMITTEE
PSYCHIATRIC EVALUATION OF CHILD AND PSYCHOSOCIAL EVALUATION OF FAMILY
FINAL ASSESSMENT BY INTAKE COMMITTEE
PLACEMENT IN CHILDREN'S DAY TREATMENT
AFTER PLACEMENT PLANNING CONFERENCE
OTHER RESOURCES
PLACEMENT IN ADOLESCENT DAY TREATMENT

B. THE CHILDREN'S DAY TREATMENT PROGRAM

The philosophy of day treatment, centers on the child and the fulfillment of his needs. In day treatment the identification of those needs is important and programming to supplement those needs is essential.

In order to program for a disturbed child, the necessity for a functional, multi-disciplinary approach becomes apparent. The child is a nucleus and his total environment influences the direction the child will take in any circumstances. Focal to the child's life is his family. Family participation in treatment involves all the disciplines in the CHILD CENTER. Progress of the family is communicated to all staff members whereby discussions are generated and focusing takes place for a particular insight. It is essential for a day treatment staff to incorporate all the factors related to a child into their everyday routine so that the focus is on individual needs. Individuality dictates that the child will function according to his or her own pace. This pace is one of the most basic issues widely recognized and used in day treatment. The recognition, however, occurs only after the child has entered and adjusted to the milieu and program. Trust is one other of the most basic issues for day treatment programs. A trusting, therapeutic relationship is formed through acceptance of the child regardless of his behavior. Behaviors are considered as external expressions of conflicts and lags. Elimination of disruptive behaviors or expressions can be accomplished through dealing with causative issues which influence the child's external expression. The day treatment staff is aware of potential acting-out behaviors of specific children from the diagnostic workup. Treatment begins by introduction of a child into the prescribed groupings and activities. The child's consequent behavior becomes then a tool for the therapist to work with. Energies are directed towards the causative factors as well as to the behavior itself and its consequences. In order to facilitate an atmosphere of acceptance and therapeutic relationship, the day treatment environment symbolizes flexibility along with honesty, objectivity, patience and empathy. This is provided in the structure,by small group settings which are extended to combined groups and then to the population as a whole. Programming is the essential vehicle in accomplishment of therapeutic relationships. Programming provides an over-all structure to the activities and the framework for the Day Treatment programs. Input from the varied disciplines concerning a particular child in relation to groups of particular children is assimilated, digested and put forth in a workable mold which fluctuates and changes dynamically as the need arises. The programming provides a routine whereby ambivalence on either the child's or the staff's part is dealt with and eliminated. This, of course, decreases unnecessary environmental anxieties and allows for a greater effectiveness in dealing with issues as they arise. The two areas of concentration in the day treatment program are educational therapy and the activity therapies (art, music, recreation, etc.)

1. Educational Therapy: Here we use education as a medium in relating to and working with the emotionally disturbed child. Great importance is attached to the understanding of a child's feelings and emotional reactions. Educational therapy does not exclude any causative factors, be it adequate former teaching, neurological dysfunction, lags, perceptual or developmental deviations, etc. It merely assumes that among the variety of possible factors due attention must be also paid to emotional conflicts and instabilities. We assume that some or most of the emotional factors causing behavior or

learning disturbance are unconscious to tne child and can be handled only through the development of a therapeutic relationship. To this extent educational therapy can be described as a psychoanalytically oriented type of treatment. However, educational therapy shares also with most kinds of remedial teaching programs, their special emphasis on carefully planned instruction. Through the subject matter of academics, the educational therapist strives to show to the child how to achieve in academics and reach grade-appropriate performance in all areas. This is accomplished by providing a stimulating academic experience, a better self= concept and a more appropriate socialization. Often disturbed children have very negative attitudes towards education or the classroom. Educational therapy deals with these attitudes in whatever way they are expressed and directs the child towards a more positive engagement in the classroom. This is accomplished through acceptance of the child, the therapeutic alliance and a particular peer relationship. Problems are handled at different individual or group levels. Educational therapy incorporates individual and group dynamics and problem solving in respect to academics and behavior. Behavior problems and their causes are dealt with at the time they occur as a process of here and now in the light of child's relationship to his therapist. Children are encouraged to verbalize feelings, frustrations and relevant issues to their actions. Verbalization is a very important tool in educational therapy but the handling of problems within a classroom situation also demands structure. A structure is needed in respect to limits while therapeutic flexibility would allow for psychological issues to be brought up and discussed. The structure of our day treatment facility provides for individualized academic programming, small class size, appropriate peer grouping and awareness of the needs of each individual child. Flexibility is achieved through the therapeutic awareness and the openness of the Educational Therapist to emotional needs of children.

2. Activity Therapy: Activity therapy programs include art therapy, music therapy, gym, woodshop, home economics, and in the summer, swimming instructions. These are an intrinsic aspect of treatment at the CHILD CENTER. Treatment with the emotionally disturbed is dependent on allowing the child to succeed in a variety of situations and to realize a sense of self-worth. Success can be attained but often success is rejected by the child and not incorporated. The function, therefore, of activity therapy is to provide success; but most important is to help the child incorporate the success and extend a sense of self-worth to other situations. It is often in the realm of activity therapy that the first signs of progress are realized with our children. The activity therapist provides a relaxed, creative and structured environment within which the children can perform at their own rate. The ability of the activity therapist to utilize the tasks at hand encourages the children to verbalize and demonstrate behaviors in a successful environment, differentiate them from those serving similar functions with other types of children. In this area of expertise, the activity therapist also deals with developing socialization skills. Emotionally disturbed children often have difficulties with expectations of appropriate social manners. They can be aggressive or extremely withdrawn; they can fluctuate from moment to moment or perform in the expected manner for a long period and then regress. Socialization is the process through which the activity therapist tries to provide a consistent model for the children's behavior and help the children incorporate this consistency in their everyday lives and interactions with others. Important in aiding the process of

socialization is the remediation of deficits which are secondary to the emotional problems. Many of the children at the CHILD CENTER have difficulty in fine and gross motor activities and perceptual problems. Remediation of these deficits has direct bearing on the ability of the child to learn to feel secure with peers in a variety of situations and to help them feel a sense of self-worth. All aspects of treatment are related. Each situation influences the performance of the child in his next activity or in his eventual termination from the program.

3. Art Therapy: Art Therapy at the CHILD CENTER includes cooperative art projects as well as individual ones. Groups are fairly small with no more than 6 children and usually less. Painting, drawing and work with clay are the most common activities, although many and varied projects are done. In cooperative projects such as mural painting, group discussion is an important part of the activity and the children are strongly encouraged to talk about what they did and their behavior while doing it. Emphasis is also on skill development since many of our children have perceptual motor difficulties. Individual projects may be very simple depending on the needs of the individual child. Projects are designed to increase success experiences and there is emphasis on the quality of the product.

An accepting, supportive atmosphere is used to encourage each child to participate and then discuss his activities. Projects and the related individual and group discussions with the art therapist are oriented toward increasing self-awareness, developing self-expression, encouraging creativity, developing perceptual motor skills, insuring feelings of success and gratification, stimulating non-verbal communication of ideas, developing appropriate social skills and accepting responsibility for behavior.

4. Expressive Therapy: Expressive Therapy is the CHILD CENTER'S expression for therapy using drama, dance and stagecrafts to help children constructively express their feelings, develop self-image and improve social skills. During drama sessions, children learn to role-play various characters in peer, family and school situations. They also work on short plays which are presented to the other children and staff. In dance sessions, the main emphasis is on developing and improving self-image. Creative movement is used to decrease the children's inhibitions and increase body awareness. Ballet and tap dance are used to develop strength, coordination and concentration. In stage craft sessions, children learn to construct scenery and work cooperatively as a member of a small group. Group size is limited to six children and most groups are smaller.

5. Music Therapy: Music Therapy, which is the use of music as a tool to change non-musical behaviors, is part of the milieu at the CHILD CENTER. Like the other therapies, almost all of the children enrolled at the Child Center participate. Groups are very small averaging three children although some times six participate. A number of children are taught on a one-to-one basis in sessions that last from fifteen to thirty minutes depending on the child's ability to attend and concentrate. Individual instruction is on the guitar or piano. Instruments used for group music sessions include tambourines, hand drums, triangles, maracas, wood blocks and the trap set. Instruction can be very, very basic with children learning their left from their right, their own body parts and eye-hand coordination. The most advanced group instruction is mini rock band. Children participating in groups are grouped by age or behavioral interactions with the more aggressive children being placed with aggressive children while the less competitive children are placed with each other.

Music therapy activities are designed to establish and maintain effective personal relationships that encourage emotional and musical growth. Activities are structured to provide success for each child at his own level of physical and psychological capability. Personal growth is made possible through elaboration of sensory and motor behavior, self-expression and development of self-esteem and gratification through success and self and others. The therapy is settup also to elicit extra musical ideas and associations for development of avenues for success outside the music therapy setting. Children have, for example, on occasion taught others in their neighborhoods and become members of bands. However, the primary aim of the music therapy sessions is to use music as a tool to reorganize disruptive behaviors into more acceptable ways of dealing with problems with a secondary goal to provide academic information about music.

6. Recreational Therapy: Gym activities, with groups of approximately 12 children, emphasizing cooperation and competition in socially acceptable ways to develop motor skills, is the focus of recreational therapy. It differs from gym athletic activities in regular school settings in that children are allowed to choose their activities and may be involved in an activity with emphasis on development of relatively elementary skills with lower expectations. There is a lot of effort to deal with unacceptable behavior by talking it out with the child in order to keep him or her within the group. There is specific selection of children for specific group, and activities are structured according to the needs of each group.

C. CHILDREN'S RESIDENTIAL TREATMENT

The children's residence is a cottage-type unit housing children whose emotional problems are severe enough to need more extensive treatment than can be offered by our day treatment program with its five day school-type organization. The residence functions from 7:00 P.M. Sunday until noon on Friday when the children leave to spend the weekend with their parents. Capacity is for eighteen children of both sexes who range in age from 5 to 13 years. Children in the residence are usually those from especially chaotic and inconsistent families and therefore the program here is very organized, planned and structured. The staff, who all have bachelors degrees, is very treatment oriented and involved, and the residence is in no way a babysitting or custodial facility. Staff members are very aware of the relationships between themselves and the children in residence as well as the relationships among the various children. The program is probably best described as a behavioral one with warm, emphatic, supportive relationships from the adult staff who are young, flexible, and adaptable. There is a sense of putting responsibility gently on the child as soon as he or she shows any readiness for it.

The residence's treatment staff includes four full-time residential therapists, two part-time residential therapists, an overnight residential therapist and the residence's supervisor. There are an equal number of male and female staff.

Admission to residential treatment is based on the following criteria:

a. Explosive uncontrollable situations at home.
b. Child's need for much greater consistency and structure.
c. Child's need for learning appropriate socialization skills.

d. Child's need for temporary separation from the home environment.
e. Child's need for enrichment experiences.
f. Child's need for appropriate adult role modeling.
g. Failure of other modalities of treatment.
h. Need for further diagnostic evaluation.

The goal of residential treatment is to further emotional growth and development so the child can return full time to his family and be more functional. It is not expected, however, that only the child should progress. Parents of children in residence are required to be involved in counseling and/or psychotherapy with a Child Center social worker or other staff member so they can better help their child.

Treatment modalities for children in residence include both individual work with the child and small and large group activities and projects also designed to foster emotional growth. Each child is actively involved with his peers, the residential therapists, nursing and psychology students, volunteers and surrogate grandparents. This is in addition to his or her schooling and related school activities in the day treatment program which all children in the residence attend. Treatment includes fostering close relationships with the residential therapists, adult role modeling, positive involvement with peers, formal behavior modification, reality therapy, life space interviewing, environmental stimulation, individual and group psychotherapy and recreational therapy. Most important is the alliance between the child and the residential therapist which is actively fostered. A variety of activities such as gardening, swimming, nature study, camping, sewing, cooking, art projects, sports and games and trips out into the community are used to form relationships with the child. Through these relationships the child and the residential therapist become able to discuss their concerns and decide on what they will do related to them.

The residential treatment staff meets formally once a week for three hours to discuss issues pertaining to each child and to plan the next week's activities. An agenda is set up with each child in mind and includes activities on a one to one basis for the child and in small or large groups with specifically selected staff members and peers. A written log is kept for each child with daily entries noting the child's responses to facilitate ongoing communication about the child to the day treatment staff, social service staff and other Child Center staff members.

Visitation of children during the weekdays in the residential treatment area is discouraged, and telephone privileges are limited. The residential treatment staff is responsible for serving meals, handling of bedtime routine, children's personal hygiene and all other routine related to everyday living. The staff share their experiences with parents through specifically designed questionnaires and forms, regular contacts and discussions, and occasionally inviting the parents to meet with the entire staff so the parents may observe interaction between the child and the staff and share their views and opinions.

D. ADOLESCENT DAY TREATMENT

The Child Center adolescent program is a self-contained unit serving approximately twenty five teenagers. There are eight staff members including the Child Center's Medical Director. Staff members teach small classes, see adolescents for group and individual psychotherapy, structure community meetings and participate in athletics and art-oriented projects. The focus is an academically oriented program (junior high curriculum) strongly supported by

group and peer alliances, caring and friendships. Living together as a "family" with the development of living skills is emphasized. To further group cohesiveness and social skills, there are regularly scheduled camping trips and a once a year trip of a week or more out of state. Parents are seen for their support of the program, communication and special management problems. Individuation and the development of autonomy and independence are emphasized. The teenager is required to actively participate in the academic program.

The program is structured along the regular five day school week with academic subjects, discussions and therapy from 9:00 A.M. to 3:00 P.M. and athletics and art after regular school hours. There is no summer break and the program continues from 10:00 A.M. until 2:00 P.M. during the summer with more emphasis on activities and less on academics during this time. Students, ages 13 through 17, who can interact in an open setting and who are capable of obtaining normal academic functioning, are eligible to attend. Class sizes are kept small (4 to 8). Treatment takes a twofold approach --- an appreciation of the adolescent as an individual and an awareness of the adolescent as a group member. As an individual, each adolescent is encouraged to express his individuality in a constructive manner. He or she is encouraged to participate in decision-making about his/her program and then to be accountable for the implementation of that program. As a community member, each adolescent is given the opportunity to express his interdependence with others.

Each adolescent is encouraged to contribute to the structure of the group and then to be responsible for the behavior of the group. Each adolescent is asked to examine not only his own feelings and expressions, but also the effect which those have upon other group members. In this respect, no less is asked of the staff, who are also expected to examine their own motivation and be aware of the dynamics involved when interacting with fellow staff and with students. Staff and students alike are encouraged to interact and to grow together. It is felt that the adolescent program staff can best contribute to the growth of the students by demonstrating their own personal desire and ability to grow both as individuals and as members of the therapeutic community. Openness between staff and students as well as among staff and among students is highly encouraged.

Educational approaches are supplemented by guidance and counseling and by individual and group psychotherapy. Each adolescent has an opportunity to develop a positive relationship with one of the staff members either through involvement in individual psychotherapy, or individual guidance and counseling. Also, each adolescent is given an opportunity to participate in group psychotherapy as well as in many small group discussions. It is hoped that by allowing both individual growth and group development, each adolescent will become aware, not only of his own individual needs and responsibilities but also of the needs and responsibilities which accompany involvement in social groups.

The adolescent day treatment staff is supplemented by two nursing students who are candidates for B.A. or master's degrees in nursing. Their participation in the adolescent program includes teaching, tutoring, and psychotherapy and counseling with individual students.

E. OUTPATIENT TREATMENT SERVICES

The Child Center offers therapy, counseling and evaluation services to families, children and adolescents who are not enrolled in the Center's residential or day treatment programs. Children, adolescents and families seen as outpatients usually do not have the severe pathology that would require the more intensive residential or day treatment programs. Treatment includes individual psychotherapy for both parent and child, as well as family, marital and educational therapy. It is usually a requirement that parents be involved in therapy as well as their child. Children and adolescents formerly enrolled in the residential or day treatment programs are frequently seen as outpatients after they leave day treatment or the children's residence, generally with the same therapist they had before.

Outpatient therapy staff includes a clinical psychologist, counselling psychologists, psychiatric social worker and educational therapists.

F. PSYCHOTHERAPY

All parents are expected to be involved in psychotherapy, be it individual, marital, family or group. The manner and frequency of therapy is determined by the staff based on the needs of the family. The majority of families are seen weekly. Psychotherapy with parents and/or families generally takes one or more of the following forms:

a. Direct Management - helping parents respond more effectively to their child's behavior.

b. Marital Therapy - exploring the family coalitions and promoting restructuring in ways that are more beneficial for family members.

c. Supportive Group Therapy - helping clients with similar needs (i.e. single parents) to work towards change and insight in a supportive environment.

G. PLANNING

Several different methods are used for administrative and clinical coordination. They are the following:

1. Department Heads: The department heads are responsible for the implementation of general guidelines. Department heads participate actively in recruiting and employing new staff members. Their main function, however, is maintaining continuity in the planning for a child and in establishing good communication among the multidisciplinary treatment team. Department heads are both administrators and therapists. They clarify and translate different matters to their staff and provide consultation, coordination and supervision, and participate in policy making as well as seeing a full caseload of clients on a regular basis. Input from department heads is thoroughly considered by the Medical and Administrative Directors in establishing policy and general guidelines.

2. Staff Supervision: Each member of the clinical staff participates in regular, individual and group supervision. This is provided in two ways: first, in the form of individual conferences usually weekly with a department head and second in a weekly department meeting held and chaired by the department head. A part of each department meeting is used to provide individual guidance to staff members who may benefit from ongoing clinical supervision. Another part is to gauge whether the staff members' work conforms to the treatment plan previously established by the treatment staff for the individual child. Other purposes of the department meetings are to jointly discuss clinical affairs which effect the entire agency or department and to deal with administrative operating procedures.

3. Multi-Disciplinary Case Review Conferences: These are conferences that are held every three months in a fashion that allows each patient's status to be reviewed in considerable detail. With participation of every staff member involved in any way in the treatment of the child, progress is assessed, diagnosis is reviewed and new and more meaningful treatment plans are made. Obviously, some cases need more frequent and more immediate intensive reviews than others. This is provided for in the form of a regular weekly meeting called "Emergency Case Reviews" with all clinical staff members present.

4. Informal Staff Meetings: Since each child has contact with a number of CHILD CENTER staff members daily, constant communication among staff is necessary to keep treatment consistent and therapeutic. Although there are numerous fairly structured regularly scheduled meetings concerning each child, very important are the daily informal and spontaneous discussions between staff members. When not directly involved with children and their parents, staff members' office doors are more often than not open and staff members are available on the spot to discuss a child's difficulties and welcome these contacts. More "conferences" that are invaluable probably occur over coffee and lunch in the staff room.

H. BUDGETING, FINANCE AND FEES

During the past two years the CHILD CENTER has received 25% of its income from the United Way of St. Louis, 25% in private donations, and 50% in treatment payments. In 1979 the total budget was approximately $760,000.

All clients are expected to pay a treatment fee out of their own pocket. This fee is based on the family's ability to pay it, which is established in a conference with the Administrative Director. Fees are not established by a fee schedule, but rather by a careful analysis of each family's individual income and expenses. No family is ever refused service for inability to afford fees.

Third party payments are frequently received from a family's individual health insurance program, a state department of mental health, or a local school district.

OPERATIONS

A. Program Schedules

The Children's Day Treatment Program operates from 9:00 A.M. to 3:00 P.M. Monday through Thursday, and from 9:00 A.M. to 12:00 noon each Friday. This is a twelve month program. The summer session which runs from mid-June through the latter part of August operates from 10:00 A.M. to 2:00 P.M. Monday through Thursday, and involves academics half the time and recreational and creative type activities the other half. At least one camping trip is scheduled for each child during the summer session. Rarely, but in the case of emergency a child in residential treatment may be kept at the CHILD CENTER on weekends. This would be for clinical reasons rather than the inability for the family to pick up their youngster. Children in residential treatment are in treatment at the CHILD CENTER five days each week and attend school-related activities with day treatment children. These children return to the residence at 7:00 P.M. on Sunday evening and return to their homes each Friday at 12:00 noon. This schedule continues during the summer. From 10:00 A.M. to 2:00 P.M. during the summer the residence children participate in the same schedule that day treatment children do.

Outpatient treatment services are scheduled on an individual basis. Normally, outpatient clients are seen in the evening or on Saturday mornings.

There is no extended holiday for the patients and staff at CHILD CENTER. In order to provide for some separation of staff and patients and to provide for additional planning time for the staff, one week breaks are scheduled in the program during the Christmas holidays, around Easter time, in mid-June and late July and in late August.

B. Transportation

Families are responsible for transporting their youngsters to and from the CHILD CENTER. The CHILD CENTER'S staff cooperates with the family in trying to assist in developing car pools or in linking transportation arrangements with the local metropolitan public service system or public school district transporters.

C. Parental Authorization

The CHILD CENTER is a psychiatric treatment center. Accordingly, much of the material at the CHILD CENTER is very personal information and is not divulged to anyone without parental authorization. Authorization to release information is signed each time information is exchanged with a third party.

D. Restrictions and Limitations on Children's Behavior

Children are not allowed to bring expensive objects, dangerous objects or toys to the CHILD CENTER. The use of alcohol or other drugs, other than that prescribed by the Medical Director, is prohibited and use will normally result in the youngster' suspension from the program for several days. Ultimately, repeated abuse could lead to the child's expulsion from his or her service program. Children are not allowed to leave the premises without

supervision, and their absences from the premises considered run-aways are dealt with clinically.

E. Students and Volunteers

Fifteen to twenty-one trainees in different mental health disciplines and related fields do rotations, practicums and internships at the CHILD CENTER yearly. These are:

1. 2 clinical psychology interns from Washington University.

2. 1 resident in child psychiatry from Washington University.

3. 4 nursing students from St. Louis University and other schools doing their psychiatric rotation.

4. 3 social work graduate students from St. Louis University or Washington University.

5. 3 to 6 special education students from Fontbonne College, St. Louis University, Washington University Webster College and University of Missouri

6. 2 music therapy interns from Maryville College and Kansas University.

All trainees are under direct supervision of the staff member in whose program they work. Their work and relationships to the children and/or families are often directly observed by the supervisory staff, and supervisory sessions are frequent and usually one to one between trainee and supervisor.

Volunteers are used extensively in the fund-raising office at the CHILD CENTER. Other volunteers work with the children and adolescents enrolled in the agency's residential and day treatment programs. Volunteers working with children are expected to make a commitment of time and energy over an extended period of time in order that their relationships are meaningful and therapeutic.

F. Meetings

Parents normally meet with a member of the treatment staff for their own counseling weekly. Usually, these are sessions provided by the psychiatric social work staff. The parents are also expected to attend quarterly conferences with the educational therapists for update on a youngster's behavioral and academic growth in the classroom.

G. Gifts and Donations

A fund raising office actively solicits additional contributions in the form of cash gifts or gifts in kind.

H. Research

The CHILD CENTER usually has several ongoing research projects directed by

the Medical Director. These projects, which include children either presently attending the Center or who previously attended or were evaluated here, are purely voluntary and are discussed thoroughly with the participating parents and child before their participation is gained. Research previously done at the CHILD CENTER has been published in the journals "Child Psychiatry and Human Development" and "Adolescence".

I. Employees

The regular CHILD CENTER staff includes:

1 Child and Adolescent Psychiatrist
2 Clinical Psychologists
1 Counselling Psychologist
4 Psychiatric Social Workers
9 Educational Therapists
7 Activity Therapists (2 art therapists, 2 music therapists, 1 expressive therapist, 2 recreation therapists)
8 Residential therapists
5 Secretaries/bookkeeper
4 Maintenance staff
2 Administrator/public relation specialist

J. Physical Plant

Four buildings provide 38,000 square feet for the CHILD CENTER'S operations. One building is the children's residence, another the classroom building for adolescents. The recreational therapy building houses a central kitchen, a large gym, an outdoor swimming pool and other offices and classrooms. The fourth building houses classrooms for children and administrative offices.